

Inquiry into teenage pregnancy

The Scottish Sexual Health Lead Clinicians Group

Do you have any views on the current policy direction being taken at the national level in Scotland to reduce rates of teenage pregnancy?

Teenage pregnancy is a symptom of wider problems and social malaise and should not be considered in isolation, but in the context of the wider social environment.

Social policy such as The Early Years Framework has the potential to reduce teenage pregnancy. Indeed research increasingly suggests that successful early childhood intervention is probably the most effective action that can be promoted.

The Sexual Health Lead Clinicians agree with the policy (as given in the Sexual Health and Blood Borne Virus Framework 2011-2015) that local authorities should take a leadership role in addressing teenage pregnancy and implementing the 'Reducing Teenage Pregnancy' self assessment tool, and that interventions should be targeted at those most at risk. We consider however, given the proven links between social inequality and incomes inequality, that policy should make explicit the role of central government in preventing teenage pregnancy particularly through management of the economy but also through employment, education and social policy.

We are concerned that focussing on teenage pregnancy detracts attention from the large amount of sexual activity that is taking place and is associated with other harms such as sexually transmitted infections and sexual coercion. We are also concerned that focussing on teenage pregnancy often leads to focus on teenage females, while the males who impregnate them are ignored.

Do you have any views on the action being taken at the local level by health boards, local authorities and other relevant organisations to reduce teenage pregnancy, particularly in the under 16 age group?

Health services can make a limited difference to social problems, but sexual health services have striven to provide a wide range of services and to be accessible to young people. As sexual health doctors we often feel that we are 'firefighting' – struggling with crisis situations rather than prevention.

RHSP (relationships, sexual health and parenthood) education is a key policy intervention but here is no monitoring and accountability, nor sanctions in place for non-compliant schools, and schools are free to determine content. If delivered as intended early years work and the Curriculum for Excellence will empower young people to develop health self esteem, make informed choices and be resilient. This is essential as social harms such as pornography cannot be adequately combated by through legislation, but young people can be equipped with the skills to evaluate and reject it.

Local authorities also need to be made more accountable for their responsibilities regarding sexual health in other areas e.g. looked after and accommodated children.

The Reducing Teenage Pregnancy Toolkit promotes raising aspirations as a key component of reducing the teenage pregnancy rate. This is an area which local authorities are struggling to implement and consideration should be given on how to support local authorities and the voluntary sector to achieve this.

Good quality Youth Work and Community Education has been shown (e.g. in the English Teenage Pregnancy Strategy) to be effective in reducing teenage pregnancy, yet these are frequently areas targeted for cuts, and certainly not for expansion.

What are your views on the relationship between high levels of teenage pregnancy and socio-economic inequality?

All the available evidence demonstrates a clear link between teenage pregnancy and socioeconomic inequality although this is not the only factor as teenage pregnancy rates vary between comparably deprived groups. There is compelling evidence showing a link between income inequality (the ratio of the lowest and highest incomes in a society) and teenage pregnancy rates (<http://www.equalitytrust.org.uk>) that remains unaddressed within Scotland. Achieving Our Potential- a framework to tackle poverty and income inequality in Scotland discusses reducing the proportion on low incomes but does not address the differential between high and low incomes which the evidence shows is a significant factor in many health outcomes, and that more equal societies have better outcomes for rich and poor.

Scotland's worst areas of social deprivation are areas that experienced deindustrialisation, which led to massive shifts in the internal dynamics of the affected communities and adaptive behaviours which have negative social consequences. Describing an outcome as a negative consequence is of course value laden- the interests of the individual and wider society may not be congruent: some teenagers may perceive their child as a good thing, while wider society bears the burden of paying her welfare benefits, educating her child etc. (ref 'Distributed Parenting' Teenage pregnancy in post industrial areas in a social medicine perspective Desmond Ryan 2001 https://docs.google.com/document/pub?id=174XvyklsJiddF4QS_ASjiupeHiafY3i_IYCDtr2A3w). When considered in this context it can be understood that there are no quick fixes for teenage pregnancy.

What are the barriers and challenges to making progress in achieving positive change in communities that might lead to reductions in the levels of teenage pregnancy?

Scotland has entrenched structural and cultural barriers to positive changes. Health services seeking to work in partnership with local authorities too often find barriers in the personal opinions of senior staff e.g. senior

managers will not allow condom distribution by local authority youth workers. This is often fuelled by the misconception that talking about sex and provision of sexual health interventions encourage young people to have sex, and a fear on the part of local authorities of bad publicity.

Teenage ambivalence towards pregnancy and contraception use is a significant barrier – this is a consequence of the mixed messages teenagers receive from society about sex and sexual behaviour .

Other barriers include

- a lack of resources : time, educational materials , premises in suitable locations, accommodation within suitable premises- e.g. there is huge pressure on health service accommodation and it is not possible to establish new or expanded services in many communities.
- a lack of funding or short term funding for interventions, which stop when the money runs out even if they have been successful
- continuity of staff- staff on short term contracts move on taking expertise with them, council staff move through reorganisation and contacts are lost.
- lack of shared vision/involvement between organisations.

Parents are quite naive of the fact that young people are sexually active so young, have so much opportunity and pressure to do it , and that alcohol has a significant role in children's sexual behaviour. Many parents don't have knowledge of service as available for young people. Parents who we talk to (e.g. as patients attending for contraception) often express anxiety about talking to their young people about puberty, relationships and sexual matters and want schools and want support with this as well as being grateful when other agencies to take this role on.

What are your views on the current support services available to young parents / young mothers, e.g. range of services, focus of services and whether services are being delivered in the most appropriate settings?

A wide range of services is available and sexual health services have striven to be accessible to young people. We have also sought to work in partnership with other services e.g. maternity services to offer sexual and reproductive health services including post-natal contraception. There is scope for greater intervention to prevent a second teenage pregnancy through greater antenatal and postnatal discussion of contraception, and to make provision at point of discharge from maternity services.

Concern has been expressed within our group about the lack of support available to young mothers in some areas who wish to return to education, and that continuing education is promoted as a routine expectation. We think sharing of good practice would be a driver for improvement in this area

Are there specific initiatives that you would wish to highlight to the Health and Sport Committee that you consider indicate good practice

with regard to reducing teenage pregnancy rates in Scotland, either in the public sector, voluntary sector or in partnership?

Several boards have produced multiagency guidance for professionals (e.g. teachers, youth workers) working with young people to support them when working with sexually active young people.

We believe there is potential from programmes such as:

1. The Family Nurse Partnership programme, (a research based early intervention starting in pregnancy and designed to support first-time mothers) has the potential to make an impact.
2. Tayside Teenage pregnancy Healthy Community Collaborative Project -an evaluated and evidence based community action model which works with communities and partnership agencies to develop sustainable interventions using both national and local evidence.
- 3..Aberdeen's locally developed DVD training packs which show young people who they will meet in services and what happens with the aim of making attending less intimidating. School nurses and community youth workers etc, can show young people these DVDs.
4. Peer education work such as has been used in Dumfries and Galloway and Edinburgh (Contraception. 2004 Aug;70(2):135-9. Faulder GS, Riley SC, Stone N, Glasier A. Teaching sex education improves medical students' confidence in dealing with sexual health issues.) and Health Buddies (peer led SHRE project) which has been evaluated well but is only available in one area of Tayside

Are there specific approaches to reducing teenage pregnancy that are not currently getting sufficient attention in order to affect positive change for children and young people?

Solutions need to be found in partnership with communities, not simply by parachuting in workers and services. The solutions will rarely have or need a label of 'teenage pregnancy solution', but will address the wider context in which teenage pregnancies occur. Young people need incentives not to get pregnant by having their horizons broadened and aspirations raised. They need to have the self belief and self efficacy to realise those aspirations. For example, youth work which occupies, stimulates and develops young people will have wider benefit than preventing teenage pregnancy.

Solutions must address societal problems and also risk taking behaviour in general, by both male and female teenagers, in particular the use of alcohol which we observe to be a significant contributor to teenage sexual activity: policy needs to take this into account. There also needs to be more joined up working in policy delivery.

All parents (male and female) should be informed about the benefits of child spacing to help them make informed choices about contraception. The WHO says 3-5 years is optimum- in developed countries as well as non-developed.

Do you have any comments on any other aspect of teenage pregnancy policy or examples of good practice that you wish to raise with the Committee?

The Government needs to endorse and strengthen interventions in schools and close working with agencies who work with young people excluded from school.

School nurses make a very positive input into the lives of young people as they are so well placed to be approachable, but are variably used across Scotland. School nurses are under increasing time pressure due to the volume of child protection work they are involved in- as well as additional work from vaccination programmes. Grampian and Ayrshire are examples of excellent school nursing involvement with sexual health. School nurses do not enough administrative support so that a lot of their time is spent on paperwork and so, where if they had more admin support, they would be able to free up time to provide ongoing care, advice, support and provision of contraception and other services to young people. A relatively small investment in more school nurses and admin would bring a very generous return.

The potential for the school nursing service to make an impact is restricted by lack of finance for posts and also timidity on the part of government and local authorities- why is emergency contraception not available in schools? Why are condoms and contraception not accessible? Vaccination against a sexually transmitted infection (HPV) is given in schools, why can't pregnancy and other STIs be prevented?

The Scottish Government is prepared to make a stand on controversial subjects like gay marriage, why does it run scared of its critics on the subject of making emergency contraception available in schools?

The Scottish government should give consideration to the availability of certain interventions in schools particularly in rural areas and areas with higher teenage pregnancies including the availability of emergency hormonal contraception in schools

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